# Provision of an out-of-hours imaging service: expectations *vs* reality

I believe there are fundamental principles underlying the provision of an out-of-hours imaging service. These include fairly dogmatic statements such as those listed on page 5 of the Royal College of Radiologists (1996) document on out of hours working, namely:

**'2.1. Only those examinations which will affect immediate patient management during the out-of-hours period should be performed.**
**2.2. Out of hours, a radiologist should only carry out those procedures that he/she is competent to perform in hours.**
**2.3. All examinations or procedures need to be performed to the usual high standard which is obtained during daytime working. Accordingly, the appropriate structures (i.e. staffing and equipment) must be available for the performance of the procedure or examination that would normally be used during in hours working.**
**2.4. On-call consultant staff must be effortlessly identifiable on a roster, and must be able to be contacted readily and easily.**
**2.5. A minimum of four consultants is required in order to provide a rota that results in a one-in-three on-call duty (allowing for annual, study and other leave).'**

## REALISTIC WISHES?

Are these highest standards achievable or is this a wish list that has no place in reality?

Let's start by considering why an imaging service needs to be provided 'out of hours' and where the demand comes from. Clinicians want it for two reasons; first clinical demand and second pressures from lack of resources, usually bed space and/or procedure list space. 'Calmanization' and the pressures which junior hospital doctors are subjected to place far greater reliance on imaging to assist making the primary diagnosis than ever before. Junior clinical staff would often rather use imaging to support their diagnosis rather than disturb their clinical consultant.

Better consultation, and hence less conflict, particularly in teaching hospitals, might well lead to improved use of imaging services and to a reduction in the level of expectation from all sides. Protocols agreed between clinicians and radiologists outlining out-of-hours service requirements might help to resolve problems, improve services and make life easier for all junior medical staff.

Trust administrators also want a 24-hour imaging service, for financial considerations, 'good publicity' or other more diverse reasons including increasing bed occupancy, reducing waiting times and increasing patient throughput. Lastly, patients want the service, naturally and quite correctly, performed to the best possible level. So what can we provide, at what level and at what cost? No simple solution exists as there are too many variables and before I attempt to answer some of the points, there are concepts that need exploring to help define strategies for individual departments and trusts.

## RESOURCE REQUIREMENTS

Since April 1 1998, chief executives are responsible for the quality of the services they provide. Thus if the trust wishes to have, for example, a 24-hour interventional radiology service, it must have the resources necessary to accomplish this. The radiologists should establish the standard but the trust must resource it. Thus it is the trust's decision whether or not to provide the service, and the radiologists should not be forced into complying with unreasonable demands, as the standard of care may well be compromised by so doing. The onus for providing the service lies with the trust and its administration: a fundamental principle which is important to establish.

The second concept is that of core skills which I have already debated elsewhere (Weir, 1998). Departmental core skills can be harnessed to provide an on-call service given a critical mass of staff. The district general hospital with three radiologists, one maybe having an interest in neuroradiology, will not be able to (and should not) run a neuroradiology on-call service unless other factors such as the following are also considered. The introduction of skills-mix, clinical protocols, extension of the working day, cross-trust cover, teleradiology, audit and other initiatives all help to provide such a service, albeit 'at a price'.

The basic problem is that there are too few radiologists in this country compared with Europe and the USA. We have 3 radiologists per 100 000 population in the UK compared with 7 in France, 10 in Sweden and 14 in the USA — need I say more? If we had a realistic manpower level in our specialty, we would not need all the other solutions listed above. We have to accept, however, that we will never approach the levels in other countries despite a recent significant increase in training numbers.

## WHAT CAN WE DO?

So what in reality can we do? We ought to demand resources to allow radiologists to make use of their time (and expertise) more efficiently, in other words: increase the infrastructure of radiology departments. This will

certainly not be cost neutral; teleradiology and picture archiving and communication systems (PACS) are not cheap but they are becoming increasingly necessary if our specialty is to cope with the ever increasing continuing clinical demand day and night.

Dr Michael Brindle, former President of the Royal College of Radiologists, once described three levels of service: the first and best was essentially unaffordable and unachievable; the second was practical, of good standard (and achievable); and the third was the basic minimum standard below which it was unacceptable to practice. We should aim for the second and under no circumstances go below the third.

## CONCLUSION

So what can we realistically achieve out of hours? To determine this we must set standards, inform management of requirements to realize those standards, develop locally agreed clinical protocols, demand resources (both manpower as well as financial and material) and then let the trust decide whether a particular service is possible or not. After all, patients are becoming well educated, they expect certain standards and levels of care to be in place, and we should use the strength of patient input to improve their care. HM

### KEY POINTS

- Trusts must develop 'realistic' on-call commitments depending on their resources.
- Patients require standards to be maintained when procedures are performed 'out of hours'.
- Cross-trust cover, flexibility, teleradiology may, along with other initiatives, be required for an 'on-call' service.
- A real increase in radiology manpower is urgently required.
- Agreed clinical protocols for 'out-of-hours' service should be established.

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Royal College of Radiologists (1996) *Advice to Clinical Radiology Members and Fellows with Regard to Out of Hours Working.* (BFCR(96)3). Royal College of Radiologists, London

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